Contraceptive Security in Honduras: Assessing Strengths and Weaknesses

April 26–May 7, 2004

USAID/LAC/RSD-PHN
Regional Contraceptive Security Feasibility Study

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Abbreviations

ASHONPLAFA	Honduran Family Planning Association
CESAMO	Health Center with Physician
CESAR	Rural Health Center
CS	Contraceptive security
ENEFS	National Epidemiology and Family Health Survey
FP	Family planning
IHSS	Honduran Social Security Institute
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
LAC	Latin America and the Caribbean
NGO	Nongovernmental organization
RH	Reproductive health
SPARHCS	Strategic Pathways to Reproductive Health Commodity Security
SS	Secretariat of Health
TFR	Total fertility rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

Primary sources for this summary include the in-country contraceptive security assessment, and demographic health surveys or national reproductive health surveys.

Executive Summary

In Honduras, the contraceptive security (CS) assessment was conducted from April to May 2004. The results of the assessment suggest that contraceptive security is attainable in Honduras, and despite many challenges, the program has taken many crucial steps in the right direction. Although there is a weak legal framework for the provision of family planning (FP) services in Honduras, the FP program has been able to make considerable advancements. In the last decade, Honduras' total fertility rate (TFR) was reduced by almost one child, from 5.2 to 4.4 children per woman.[1] The use of modern contraceptives among women in union increased from 47 percent in 1991 to 50 percent in 1996 and to 62 percent in 2001. This increase was greater in rural areas, where the increase was from 36 percent to 54 percent, while in urban areas the increase was from 61 percent to 70 percent.

Currently, the government's National Heath Policy for 2002–2006 identifies the reduction of maternal and child mortality as a priority and the government's responsibility for ensuring the availability of essential medicines and their uninterrupted supply at all health facilities. The Secretariat of Health (SS) recently developed a plan for the National Health Initiative to Reduce Maternal Mortality, which includes the spacing and prevention of pregnancies as one of 11 key strategies.

The Secretariat of Health (SS) is the main provider of FP/reproductive health (RH) services (40% of all services in 2001) in Honduras. The availability of free contraceptives in public sector facilities has contributed in large part to the increases in contraceptive use in Honduras. The Honduran Social Security Institute (IHSS), however, has decreased its provision of FP services over the last decade since FP services are not included in its benefits package. The nongovernmental organization (NGO) sector is also an important provider of FP services. The International Planned Parenthood Federation (IPPF) affiliate, the Honduran Family Planning Association (ASHONPLAFA), is the second largest provider of services (29% of total provision) in the country.

In Honduras, USAID has been the principal supplier of contraceptives since 1995, and between 1995 and 1998, the only donor of contraceptives to the SS. UNFPA provided intermittent support to the SS in 1999 and then again in 2002. The IHSS has also received sporadic contraceptive donations from USAID and UNFPA, and unlike the SS, the IHSS does not procure contraceptives. USAID plans to continue contraceptive donations to the SS for the next three to four years. ASHONPLAFA has been receiving donated contraceptives from IPPF and USAID. ASHONPLAFA's cooperative agreement with USAID will end shortly, but it has not been determined how much support they will continue to receive. In general terms, the donation of contraceptives has been highly irregular from all sources, resulting from a lack of planning and coordination among donors. There is definitely a need for an integrated commodity phase-out plan that allows the public sector and NGOs to project their future needs for FP services.

[1] National Epidemiology and Family Health Survey (ENEFS), 1996 and 2001.

The SS has established a precedent for purchasing contraceptives and has gradually expanded the range of methods being procured. It began in 1999 by purchasing condoms only; in 2002, it purchased condoms and injectables and then intrauterine devices (IUDs) and oral contraceptives the following year. In an effort to increase transparency in government procurement procedures, in 2003 the SS conducted its entire purchase of medical supplies (including contraceptives) through a special agreement with the United Nations Development Program. The population growth over the next decade will continue to increase the demand for contraceptive methods and will almost double the total number of users. To meet the contraceptive requirements for 2015, the SS will need to increase its budget for contraceptives by 18 percent annually[2].

Contraceptive security in Honduras will not be achieved without sustained political leadership and popular support. This will require a clearly articulated government commitment to ensure that contraceptive methods are available for all and that family planning is considered a priority issue. The leaders at the highest levels of government should demonstrate their commitment, but contraceptive security will also depend on the individuals and organizations that influence decisionmaking at all levels of society. In spite of the fact that the Honduran FP program will face many future challenges, Honduras has a significant advantage in the fact that there is a reasonable timeframe (three to four years) before USAID support for commodities is ended. This time will be critical to generate sufficient support for contraceptive security.

[2] This 18 percent increase assumes that the SS will purchase contraceptives at intermediate prices. If, however, they are able to obtain contraceptives at low prices, the SS will only need to increase its budget for contraceptives by 11 percent annually.

Introduction

Within the Latin America and Caribbean (LAC) region, contraceptive security has become an increasingly important issue. While USAID and many other international donors have supported family planning for more than three decades, donor investment is now declining, and contraceptive donations have been or are being phased out in many LAC countries. At the same time, the demand for contraceptives continues to grow as the region's predominantly young population passes through its reproductive years.

It is in this climate that USAID and UNFPA country offices are working with host governments and NGO recipients to address contraceptive security. To support these efforts, USAID's Bureau for Latin America and the Caribbean (LAC/RSD-PHN) conducted a regional contraceptive security assessment to guide future policy and programmatic decisions at the regional and country levels. USAID's DELIVER and POLICY II projects implemented the assessment in Bolivia, Honduras, Nicaragua, Paraguay, and Peru. The assessment was designed to address the following issues:

- What are the priority CS issues shared by most USAID-assisted countries in the LAC region?
- What are the most promising regional interventions to address these issues?
- How should future regional assistance be structured to maximize benefits?
- What are the national-level issues that should continue to be dealt with in-country, and why are they not appropriate for "regionalization"?

These activities were initiated in July 2003 during a regional CS conference in Nicaragua designed to raise awareness about contraceptive security and stimulate dialogue. During this meeting, representatives from each participating country formed a Contraceptive Security Committee designed to take the lead on CS issues and serve as a liaison in the CS assessment in those countries that formed part of the regional study. The CS assessment was conducted in Honduras during April and May 2004.

Background

In 2003, the Honduran population was estimated at 6.6 million, with 53.6 percent of the population living in urban areas. Approximately 64.5 percent of households live in poverty, and 40 percent of households live below the international poverty line. In the last decade, Honduras's TFR was reduced by almost one child, from 5.2 to 4.4 children per woman.[1] The decrease in urban areas was from 4.3 to 3.6 children per woman, and in rural areas from 6.5 to 5.6 children per woman. In the two main cities, Tegucigalpa and San Pedro Sula, the decline in TFR was less, from 3.5 to 3.1. Although the gap between main cities and rural areas has declined, it continues to be more than two children per woman. The changes in TFR correspond to the increases in contraceptive prevalence observed during the same period. The use of modern contraceptives among women in union increased from 47 percent in 1991 to 50 percent in 1996 and to 62 percent in 2001. This increase was more important in rural areas, where the increase was from 36 percent to 54 percent, while in urban areas the increase was from 61 percent to 70 percent. As a result, the gap in contraceptive prevalence according to place of residence was reduced. Obviously, these important improvements in the contraceptive prevalence rates are the result of consistent government support of FP/RH services over the years. Compared with other countries in the region, Honduras is among those countries with the highest contraceptive prevalence rates.

[1] ENEFS, 1996 and 2001.

Family Planning Services in Honduras

The SS is the regulatory and normative body for the health sector. Its responsibilities include planning, regulating, coordinating, and evaluating all public health programs. It is also responsible for strengthening the provision of services and focusing special attention on the marginalized sectors of the population. In 2001, the SS received 45 percent of all health revenues and covered 41 percent of FP users.

The IHSS is the primary provider of healthcare services for individuals that are formally employed. The IHSS is financed through quotas paid for by employers and employees and covers 11 percent of the population with a health infrastructure that is focused on large cities and municipalities. In 2001, the IHSS received 9 percent of all health revenues but covered only 4.5 percent of FP users. Currently, the IHSS receives its contraceptive supplies from the SS, yet the majority of IHSS affiliates receive their FP services through NGOs and the SS. With support from UNFPA, the national police have incorporated gender issues in their programs, including intra-family violence, family planning, and condom use. However, their overall participation in family planning is limited.

Honduras has a very active NGO force working in FP/RH, which depends in large part upon contraceptive donations. ASHONPLAFA is the second largest provider of FP/RH services in Honduras and operates six regional clinics along with 18 other clinics. They have a well developed community outreach program with 1,631 community distribution points as well as a social marketing program that caters to 600 pharmacies, supermarkets, gas stations, and other sales points.

International Donors

In Honduras, USAID has been the principal supplier of contraceptives since 1995, and between 1995 and 1998, the only donor of contraceptives to the SS. UNFPA provided intermittent support to the SS in 1999, and then again in 2002. The IHSS has also received sporadic contraceptive donations from USAID and UNFPA, and unlike the SS, the IHSS does not procure contraceptives. USAID plans to continue contraceptive donations to the SS for the next three to four years. ASHONPLAFA has been receiving donated contraceptives from IPPF and USAID. ASHONPLAFA's cooperative agreement with USAID will end shortly, but it has not been determined how much support they will continue to receive. In general terms, the donation of contraceptives has been highly irregular from all sources, resulting from a lack of planning and coordination among donors. There is definitely a need for an integrated commodity phase-out plan that allows the public sector and NGOs to project their future needs for FP services.

Findings from the Contraceptive Security Assessment

The DELIVER/POLICY team used the Strategic Pathways to Reproductive Health Commodity Security (SPARHCS) Framework to guide the assessment. The key findings from each element of the framework are described below.

Environment

The legal context for access to FP/RH services is weak. There is only one current law focusing on equal opportunities for women that specifically mentions the woman's right to exercise her RH rights. The current administration has focused on the reduction of maternal mortality and the transmission of HIV/AIDS as two key health priorities. Since the reduction of maternal mortality is closely linked to the availability of FP services, the FP program, without explicitly being mentioned, falls within this programmatic area. Fortunately, there is little public opposition to family planning, so many organizations are able to implement their programs without any major obstacles. There has been some recent strong opposition by conservative organizations to the provision of emergency contraception by NGOs, which is currently not included in the FP norms of the SS.

Client Demand and Use

Although Honduras has increased its contraceptive prevalence rate in recent years and achieved a relatively well balanced method mix, work still must be done to guarantee that all Hondurans are able to obtain and use contraceptive methods consistent with their desires to limit or space future births. There is still high unmet need for family planning, particularly among extremely poor (23%) and poor (11%) women. The lowest contraceptive prevalence rate is in Region 5, the area with the highest poverty level in the country. The barriers for women with limited resources are related to lack of trained public sector providers and frequent shortages of contraceptive supplies.

The method mix in Honduras has changed somewhat in recent years. Although sterilization continues to be the most widely used method, over the last decade both injectables and IUDs have had the largest increase in utilization among all socioeconomic levels. The injectable, which was not even included in the method mix in 1996, is now used by 15 percent of women in union. The IUD increased from 11 percent in 1991 to 15.5 percent in 2001. There has also been an important reduction in the use of traditional methods, but these methods are still most used among poor women. While the use of condoms has increased somewhat, vasectomy is practically nonexistent.

The growth of the population over the next decade will continue to increase the demand for contraceptive methods and will almost double the total number of users. The government will need to make a considerable effort to attend to the poorest segments of the population.

Services

The SS is organized into nine regional districts. Within the organization, the General Directorate of Health Promotion and Protection is specifically responsible for FP/RH services. The health establishments are divided into hospitals, health centers that have both medical and nursing staff (CESAMOs), and rural health centers staffed by auxiliary nurses only (CESARs). The SS developed a system for charging clients at public health facilities in 1990 when it published the Regulation and Manual for Cost-Recuperation. This norm establishes the prices for different health services as well as general procedures on how these funds should be used. In this norm, family planning as well as five other basic health services–immunization, prenatal care, growth and development, tuberculosis, and sexually transmitted diseases–should be provided for free. However, an evaluation conducted by the SS revealed that these services are not provided free in all circumstances. In the case of family planning, 18 percent of health establishments charge for services with an average charge of 2 lempiras per visit.

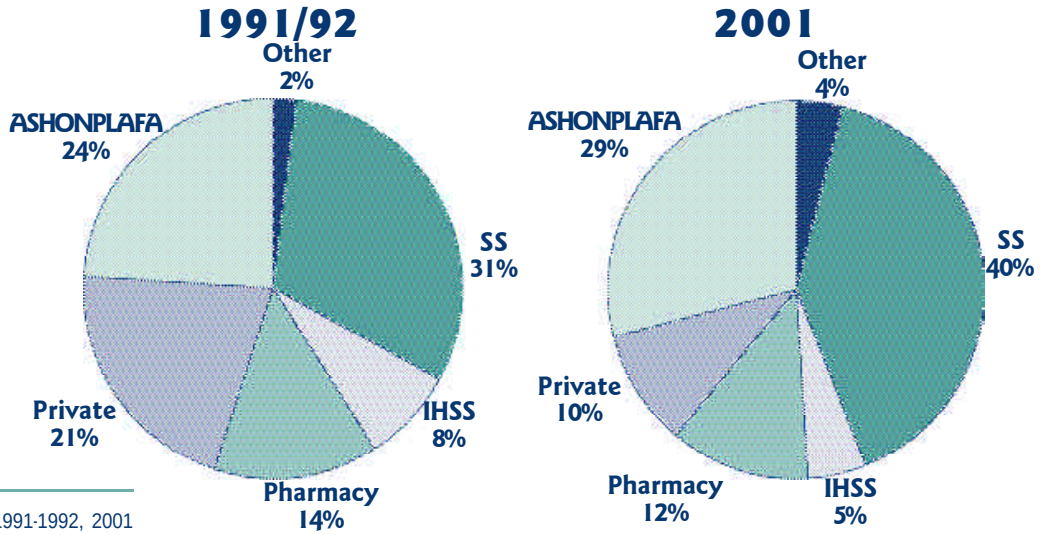
During the CS assessment, the majority of outlets had contraceptive supplies, and it appears that the contraceptive supply is not a barrier to access. The IUD appeared to be overstocked in some facilities. While the health personnel do provide information and counseling on FP services, they are not equipped with a procedures manual for the provision of FP services. In many cases, supplies are provided only on a monthly basis, which requires that the user return each month to receive her method. While there are medical and nursing staff trained in IUD insertion, they are not available in all health facilities. As a result, many facilities are not able to provide IUD services, so these facilities only provide a limited range of methods. In addition, some health facilities have only one health assistant, and when that person is unavailable, services are suspended. While some facilities do charge for the FP consultation, there are also exemptions for users that cannot afford to pay.

Market Segmentation

In 2001, the main service providers in Honduras were the SS (40% of total contraceptive provision), ASHONPLAFA (29% of total provision), pharmacies (12% of total provision), private/commercial providers (10% of provision), and others (see Figure 1). Health service provision by the IHSS has decreased over the last decade because family planning is not included in the benefits package.

The availability of free contraceptives in public sector facilities has contributed in large part to this increase and to the high rate of contraceptive use in Honduras. This has also created a high dependence upon the public sector and a consequential decrease in private sector market participation. The SS should examine ways to target FP services and products to the poorest populations who do not have the ability to pay, thereby redirecting services to the private sector**.** Additionally, it is important to note that IHSS affiliates often seek services outside of the SS system.

Figure 1. Changes in Sources of Contraceptives and Condoms



Source: ENESF 1991-1992, 2001

Financing

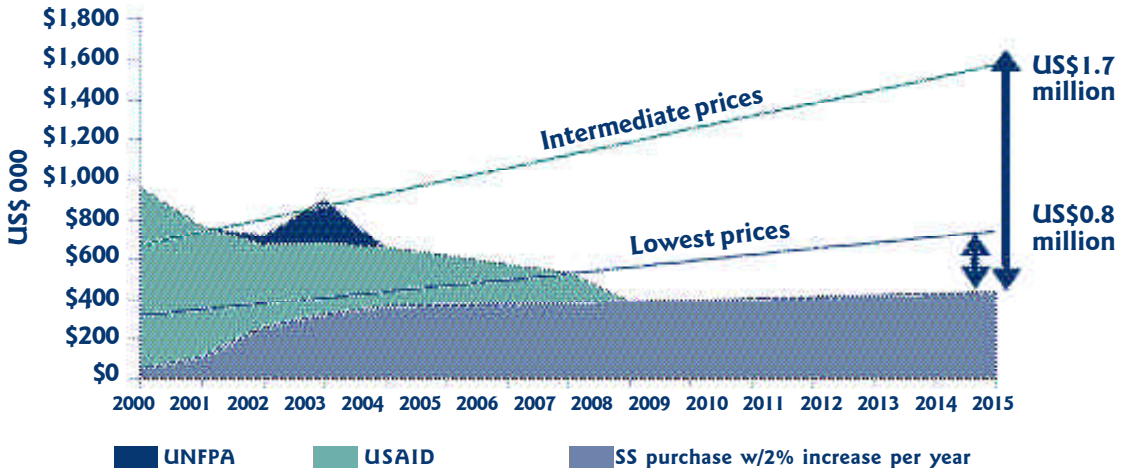
The main providers of contraceptives in Honduras are the SS, ASHONPLAFA, and the IHSS. Until 1990, over 90 percent of contraceptives provided by these three institutions came from international donations (USAID, UNFPA, and IPPF). USAID has been the main FP donor in Honduras and provided 83 percent of donations from 1999 to 2003. Beginning in 2001, the SS and ASHONPLAFA began to purchase their own contraceptives. In 2003, the SS purchased approximately US$200,000 in contraceptives. ASHONPLAFA purchased approximately US$100,000. The SS, according to national health policy, establishes that FP services (along with five other services) are to be free of charge. However, 18 percent of health centers charge for FP services.

Using SPECTRUM, ENESF 2001 and census data, contraceptive requirements were projected from 2001 to 2015, at both low and intermediate unit prices. Projections for the public sector and for the NGO sector were calculated separately.

At low prices, the SS's annual contraceptive requirements will increase from just under US$400,000 in 2001 to US$800,000 in 2015 (based on UNFPA costs). At intermediate prices, they double in future years, increasing from just under US$700,000 in 2001 to US$1.7 million per year by 2015. In 2003, procurement of contraceptives by the SS was limited, totaling US$200,000. The SS funding gap projected for the year 2015 at low prices could be closed by increasing SS purchases of contraceptives by 11 percent annually from 2004 onward.

Given the government's emphasis on reducing the transmission of HIV/AIDS in Honduras, it is also important to consider the role of condoms for both family planning and HIV/AIDS. Until 2003, the needs of the country had been covered primarily by donors, but donations have decreased significantly in the last two years. Given the demographic growth and anticipating an increase in the use of condoms among sexually active men, the financial requirements for condoms will increase from US$245,000 in 2004 to US$885,000 in 2015.

Figure 2. SS Contraceptive Funding Gap, 2000-2015



Procurement

The SS has initiated purchases of contraceptives since 1999 in increasing quantities, although in 2003 the procurement levels were less than the previous year. Until 2001, the SS had purchased only condoms; in 2002, they purchased condoms and injectables, and they purchased IUDs and oral contraceptives the following year. In 2003, the SS conducted its entire purchase of medical supplies (including contraceptives) through a special agreement with the United Nations Development Program in an effort to increase transparency in government procurement procedures. In addition, contraceptives are included on the essential medicines lists and are usually considered supplies, not medicines. However, the list should be updated to reflect the current and future contraceptive products that the SS will procure and supply for its services.

Logistics Management

Some weaknesses in the SS's logistics management system need to be addressed to maximize efforts to achieve contraceptive security. For example, currently the SS's central warehouse reports serious shortages of some contraceptives, but it is important to examine the methodology used for contraceptive programming and distribution. In general, medicines and supplies are distributed from the central warehouse to regional warehouses. Regional warehouses distribute supplies to area warehouses, and then supplies are distributed to health units (CESAMOs and CESARs) with the assistance of physicians, nurses, and nursing assistants and periodic visits from the area representatives. The provision of supplies is based on annual requests that are distributed quarterly. This type of programming and distribution is causing oversupply in some health centers while it reports stockouts at the central level. In addition, the central warehouse estimates need based upon quantities issued to the regions, rather than on consumption data. The information channels and delivery of medicines do not always follow the normative procedures because, in many instances, the areas and health facilities go directly to the central warehouse to receive their medical and contraceptive supplies. All of these factors contribute to

an inefficient distribution system that will inhibit the FP program's ability to quantify its real needs, and therefore, achieve contraceptive security.

Policy

Honduras has no legal framework or institutional support for the provision of FP services. The only existing law that mentions reproductive rights is the Women's Equal Opportunity Law of 2003. Article 19 of the law mentions the woman's right to exercise her reproductive rights, decide the number of children in conjunction with her partner, and space her pregnancies, but there is no mention of the government's responsibility in providing services. The current administration has developed a National Women's Policy for 2002–2007 that mentions the need to expand and strengthen the provision of FP counseling and services so that women can exercise their reproductive rights. In addition, the government's National Heath Policy for 2002–2006 identifies the reduction of maternal and child mortality as a priority and the government's responsibility for ensuring the availability of essential medicines and their uninterrupted supply at all health facilities. The SS recently developed a plan for the National Health Initiative to Reduce Maternal Mortality, which includes the spacing and prevention of pregnancies as one of 11 key strategies.

Leadership and Commitment

Contraceptive security in Honduras will not be achieved without sustained political leadership and popular support. This will require a clearly articulated government commitment to ensure that contraceptive methods are available for all and that family planning is considered a priority issue. The leaders at the highest levels of government should demonstrate their commitment, but contraceptive security will also depend on the individuals and organizations that influence decisionmaking at all levels of society.

In spite of the fact that the Honduran FP program will face many future challenges, Honduras has a significant advantage in the fact that there is a reasonable timeframe (three to four years) before USAID support for commodities is ended. This time will be critical for all programmers and managers to generate sufficient support for contraceptive security.

Coordination

Although there is openness to increased coordination among public, private, and international organizations, there has been little coordination to date on the issue of contraceptive security. Although several representatives from Honduras attended the Managua meeting in July 2003 and formed the Contraceptive Security Committee, the committee has been inactive. During the CS assessment, the committee was consulted on several occasions. It appears that there is interest in reactivating the committee and further diversifying its membership to include not only the SS, NGOs, USAID, and UNFPA, but also the IHSS, other donors, and members of civil society. ASHONPLAFA has participated in the initial meetings, but other NGOs and civil society organizations such as Marie Stopes International, the Center for Women's Rights, and the Center for Studies on the Honduran Woman should also be included to strengthen the committee.

Recommended Strategies and Next Steps

Strategy 1.

Ensure that public resources for the procurement of contraceptives are properly contemplated in the country's national budget. It will be important to allocate a specific line item in the national budget and raise funding for contraceptives in order to cover the funding gap created as USAID donations end.

- Lobby high-level decisionmakers within the SS and Secretariat of Treasury about the importance of contraceptive security and the phaseout of international donations over the next three to four years.
- Increase contraceptive procurement levels incrementally. There should be a minimum of an 11 percent increase in the budget annually for contraceptives, if the SS is able to purchase commodities at low prices.
- Recognize that public sector resources alone are not sufficient for the country's FP needs. Negotiate a phase-out plan with international donors based on actual requirements.

Strategy 2.

Deliberately segment the contraceptive market by targeting government-subsidized contraceptives to those who need them most and simultaneously providing incentives and encouraging strategic alliances that increase the private sector's role in supplying contraceptives to those who can afford to pay for them.

- Examine the existing practice of charging for FP services in some SS facilities and determine what strategies are needed to develop mechanisms for targeting free contraceptive methods to those who need them most. Encourage those clients that can afford to pay to visit private sector facilities.
- Develop special strategies to reach underserved populations, especially for poor women, women in rural areas, young women, and those with little or no education.
- Ensure that condom donations do not impede existing efforts to strengthen the commercial markets for condoms through existing social marketing products. There are reported problems of leakage of public sector condoms.

- Continue discussions with the IHSS to ensure that the IHSS meets the needs of its beneficiaries for contraceptives and/or that the SS receives adequate remuneration for serving IHSS clients.
- Consider the opportunities for strengthening private sources for a low-cost injectable. There is a niche in the existing commercial market for a low-cost product, but market growth strategies should be targeted toward the overall market rather than subsidizing a single brand.
- Consider strategies for integrating the commercial sector in the dialogue about contraceptive security. Consider inviting them to attend one or more follow-up sessions of the CS Committee.

Strategy 3.

Develop a specific strategy for the phaseout of support and commodity donations to NGOs that are still dependent on international donors for the majority of their support. ASHONPLAFA, for example, has not reached an adequate level of sustainability to cover its target populations, especially the poorest and most geographically dispersed populations.

- Support NGOs in their efforts to identify contraceptive supply alternatives. To date, condoms are the only method that appear to be easily available to NGOs within the region. Supply of other hormonal methods continues to be a problem for NGOs.
- Develop a clear phase-out plan for NGO support so these organizations know how much support they will receive and for how long. Examine the cost issues of reaching hard-to-reach groups, and determine whether NGOs can and should continue to play a role for these underserved audiences because the provision of services to these groups is not sustainable.

Strategy 4.

Develop a plan to strengthen the government's logistics supply system as a key strategy to ensure that contraceptive commodities are effectively and efficiently distributed to public sector facilities and that issues of overstocking are addressed.

- Conduct immediately a complete inventory of contraceptives at the national level that will provide information about current supply within the health system to assess whether there are real shortages for contraceptives.
- Put mechanisms into place to develop and implement a contraceptive logistics system that provides accurate and standardized information.
- Provide training for personnel in charge of medicines and contraceptive supplies, and clarify the roles and responsibilities for the persons in charge of contraceptive supply at the facility level.
- Update the Essential Drugs List to accurately reflect products that the public sector offers to eliminate confusion, similar to what has occurred with Depo-Provera.

Strategy 5.

Advocate for future health sector and government reforms that preserve past FP achievements and improve the population's ability to choose, obtain, and use contraceptive methods in the future.

- Advocate for an improved legal framework that confirms the role of the government in providing contraceptives. Develop the necessary political support for contraceptive security at the national and departmental levels.
- Strengthen the CS Committee and the technical capacity of its members so that they can play a more effective role in advocating for contraceptive security. Seek high-level support of the committee from key decisionmakers. Improve the committee's role in advocacy, civil society participation, and use of demographic data and cost information to update and use the financial projections about contraceptive costs.
- Develop a strategy for working with civil society and consumer watch groups at the regional and national levels. Involve these groups in protecting sexual and reproductive health rights, monitoring the services of the SS, and lobbying to increase the FP budget.
- Sensitize departmental decisionmakers about the importance of including contraceptives in their budgets and workplans. Identify, orient, and work with leaders at the regional level to ensure that contraceptive security is on their agenda.

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